SHARON REGIONAL HEALTH SYSTEM
Advanced Care Close to Home

Business Office • 699 East State Street • Sharon, PA 16146 • 724-983-3820 • www.sharonregional.com

The following information is *required* in order to process your financial aid application:

- ☑ A completed charity application. Please complete **all** areas of the application.
- ☑ Three (3) months of most recent bank statements for all bank accounts. You must provide complete copies of all pages of the statement.
- ☑ Proof of *ALL HOUSEHOLD INCOME*. Some examples of income include social security, three most recent pay stubs, unemployment, workers compensation, child support, alimony, etc.
- ☑ For self employed individuals, return the entire previous year personal and business tax returns, which include itemized deductions (such as a schedule C). Return three complete months of any bank statements for the business.
- ☑ If you have applied for Medical Assistance through the state, provide a copy of the determination notice.
- ☑ One charity application will need completed per family. A family unit includes: an individual, spouses who reside together, children under the age of 18 years and are still in high school.

If you have any questions, please contact customer service at 724-983-3820.

SHARON REGIONAL HEALTH SYSTEM
APPLICATION FOR CHARITY CARE

Please complete front and back. Return by ________________
to Sharon Regional Health System, Business Office, 699 E. State St., Sharon, PA, 16146-2096
Phone: (724) 983-3820 or (800) 950-9981

PATIENT NAME:________________________________ Soc Sec No:________________________
Address:____
City/State/Zip:__________________________________ Home Phone:________________________
Date of Birth:___________________

FAMILY MEMBERS

NAME	RELATIONSHIP TO PATIENT	SOC.SEC.#	DATE OF BIRTH	OUT OF HIGH SCHOOL Y/N?

** Please attach a separate paper if additional space is required.*

TOTAL NUMBER IN FAMILY UNIT (Including patient and guarantor): _________

APPLICATION WILL NOT BE PROCESSED WITHOUT PROOF OF ALL INCOME AND DISCLOSURE OF ALL RESOURCES, ASSETS AND LIABILITIES.

GUARANTOR
Employed by:____
Address:____
Phone:_____________________________________ Length of Employment:______________________
Hrs Worked per pay________ Gross Income:$____________ Monthly_____ Weekly______ Biweekly____

OTHER
Name:____
Employed by:____
Address:____
Phone:_____________________________________ Length of Employment:______________________
Hrs Worked per pay________ Gross Income:$____________ Monthly_____ Weekly______ Biweekly____

OTHER INCOME: *(Include social security benefits, pensions, welfare, unemployment or workers compensation, alimony, child support, disability from employer, rental income etc.)*
Source of Income:________________________________ Monthly Gross: $______________________
Source of Income:________________________________ Monthly Gross: $______________________
Source of Income:________________________________ Monthly Gross: $______________________
TOTAL GROSS MONTHLY INCOME: $____________

List health insurance coverage you have had within the past six months:_______________________________________
______
If employed full time, does your employer offer health insurance? YES_______ NO__________
Do you have Major Medical coverage? YES_________ NO_________ If yes list:__________________________
Have you applied for State Medical Assistance within the past six months? YES_____________ NO________

ASSETS

TYPE	HOLDER	BALANCE/VALUE
Checking Account	____________________	$____________________
Savings	____________________	$____________________
Rental Property	____________________	$____________________

Other (example:401K,CDs,IRAs,etc.)

____

____

LIABILITIES

TYPE	TO WHOM INDEBTED	CURRENT BALANCE	MONTHLY PAYMENT
Mortgage / Rent	____________________	$__________	$__________
Auto Loan	____________________	$__________	$__________
Personal Loan	____________________	$__________	$__________
Credit Cards	____________________	$__________	$__________

Other (please describe)____

____

I hereby grant Sharon Regional Health System permission to investigate my financial status and run a credit report, if necessary, for the purpose of ascertaining my eligibility for Sharon Regional Health System's Charity Care Program for assistance with payment for services provided therein. I certify that to the best of my knowledge all information listed is true and correct.

APPLICANT :________________________________ DATE:______________
(Signature)

PLEASE NOTE: The Charity Care Program applies only to self-pay bills for hospital services provided at SRHS. Hospital bills assigned to a debt collection agency are not eligible for consideration. Bills you may owe to your physician, surgeon, cardiologist, radiologist, ER physician, anesthesiologist, or for other medical services, such as prescription medications or ambulance services, cannot be adjusted through this program.

(Office use only)

STATUS: ______Denied or ______Approved at__________%

ACCOUNT NO.	BALANCE
______________	$__________
______________	$__________
______________	$__________
______________	$__________
______________	$__________
TOTAL:	$__________

Submitted:______Date:________ Approved:________________________DATE:________
(Initials)

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